



Consulate General of the United States of America

P. O. Box 554

**2, Walter Carrington Crescent, Victoria Island
Lagos, Nigeria**

Date: _____

FOR THE EXAMINING PHYSICIAN:

**EACH FORM OF-157 (FS-398) SHOULD BE ENDORSED BY THE PANEL PHYSICIAN
AS FOLLOWS:**

I certify that the person covered by this report is the bearer of Passport No. _____

issued by _____ on _____

Dear Sir:

You are requested to perform a medical examination of _____
in accordance with provisions of "Technical instructions for Medical Examination of Aliens" of the
United States Public Health Service, which is in your possession, and to report to results on the attached
Form FS-398 (OF-157).

Please note that in accordance with Section 34.4 (pages 1-3) (pages 1-3) of the Technical Instructions
cited above, neither a chest x-ray examination nor a serologic test for syphilis shall be required if the
applicant is under the age of 15. A tuberculin test may be required, however, where there is evidence of
contact with a known case of tuberculosis or other reason to suspect infection with tuberculosis. A
serologic test may be required where there is a reason to suspect infection with syphilis.

X-Ray For Pregnant Women

A postponement of the chest x-ray of a pregnant female is permissible; however, it is the position of the
United States Public Health Service that it is possible to perform safely the examination during preg-
nancy with proper shielding of the abdomen. It should be explained to the applicant that if the x-ray
examination is postponed, the issuance of the immigrant visa will also be postponed until such time as
the medical examination can be completed. Public Health Service regulations do not authorise a classi-
fication based only on a tuberculin skin test.

FOR THE APPLICANT:

VISA MEDICAL EXAMINATION Information Sheet and Referral Letter

1. A medical examination is required of all applicants for immigrant visas. **NO APPLICANT WILL BE INTERVIEWED PRIOR TO THE RECEIPT OF THE RESULTS OF THE MEDICAL EXAMINATION AND TESTS.**
2. **Approved Examiners:** Medical examinations must be performed by physicians designated by the Embassy according to procedure prescribed by U.S. Law. The examining physicians are not employed by the U.S. Government.
3. **Fees:** Examination fees are paid by the applicant and are paid directly to the medical facility.
4. **Report of Examination:** The examining physician will either forward the completed report to the Embassy or hand it to you in a sealed envelope for presentation to the Consular Officer.
5. **Referral Procedure:** The following indicates the physician and institution by whom you must be examined. You only need to go to the location. Please provide the examiners *with 2 copies of your passport photograph.*
6. **Hours of Examination:** A minimum of three working days must be allowed to complete the medical examination process. At times, the process may take longer than three days. Please note the following hours of examination:

Monday - Friday
Saturdays

Dr. K. A. Omotosho
KAMORASS Specialist Clinics
238A Muri Okunola Street
Victoria Island
Lagos.
Tel: 01-2612799

8:00 a.m. - 5:00 p.m.
9:00 a.m. - 2:00 p.m.

Appointment times for the physical examination will be given during the first visit. The physical examination cannot be performed until the lab. test results are available. Please further note that you will be required to appear on two separate days - one day for x-rays and laboratory tests; another day for examination and results.

Procedure for Safeguarding Pregnant Women During X-Ray

The Bureau of Radiological Health, Food and Drug Administration and Public Health Service have provided the following information: "Non-abdominal examinations, when conducted with appropriate technique factors, collimation and abdominal shielding, contribute only negligible exposure to the embryo or fetus. (Collimation refers to adjustment by the operator of the size of the x-ray beam so that it is no larger than the film). With specific reference to *chest x-rays*, we have calculated the estimated radiation dose to the embryo or fetus for each type of 14 x 17 film (AP, PA and lateral). With adequate collimation, a single PA film delivers 0.09 millirad (mrad) to the embryo or fetus which is essentially negligible. This assumes that the operator adequately collimates the x-ray beam. Further assurances of protection can be achieved by requiring that the abdominal area of the women be shielded with a lead apron."

Doubtful Cases

Whenever further medical consultation is deemed advisable, the visa applicant should be referred to an appropriate specialist at the applicant's expense. Under generally accepted medical procedures, the specialist should report his findings and opinion to the Panel Physician who remains responsible for the completion of Form OF-157 (FS-398) and final results of the medical examination. In those comparatively rare instances where no specialist is available for consultation, Panel Physicians may refer specific problems to the Embassy which will in turn refer the case to the Public Health Service in the United States.

It is absolutely essential that any practitioner performing any part of this medical examination take proper care in identifying the applicant by comparison with his photograph. Special attention should be given to ensure that specimens submitted by the applicant are from the applicant and not a third party.

HIV TESTING

A blood test for antibody to the Human Immunodeficiency Virus (HIV) is required as part of your medical examination if you are age fifteen (15) or older. HIV is the virus that is the cause of the Acquired Immune Deficiency Syndrome (AIDS). AIDS is the name given to the group of illnesses which may occur in persons infected with HIV. Infection with HIV causes a defect in a person's natural immunity against disease. This defect leaves infected people vulnerable to serious illnesses that would not usually be a threat to anyone whose immune system was intact. This test is not to diagnose AIDS, but to detect antibodies to the virus. If the result is positive, it does not necessarily mean that you have AIDS or will get it.

The results of your test will be provided to a consular officer. Also, it may be necessary to report results to the health authorities in this country. A positive test result may mean that you will not be eligible to receive a visa. A positive test result could also have other local consequences on your day-to-day activities in the country.



U. S. Department of State
**MEDICAL EXAMINATION FOR
IMMIGRANT OR REFUGEE APPLICANT**
For use with TB Technical Instructions 1991 and the DS-3024

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Photo

Name (Last, First, MI.) _____
Birth Date (mm-dd-yyyy) _____ Sex: ☐ M ☐ F
Birthplace (City/Country) _____
Present Country of Residence _____ Prior Country _____
U.S. Consul (City/Country) _____
Passport Number _____ Alien (Case) Number _____

Date (mm-dd-yyyy) of Medical Exam _____ Date (mm-dd-yyyy) of Prior Exam, if any _____
Date Exam Expires (6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy) _____
Exam Place (City/Country) _____ Panel Physician _____
Radiology Services _____ Screening Site (name) _____
Lab (name for HIV/syphilis/TB) _____

(1) Classification (check all boxes that apply):

☐ **No apparent defect, disease, or disability** (see Worksheets DS-3024, DS-3025 and DS-3026)

☐ **Class A Conditions** (From Past Medical History and Physical Examination Worksheets)

- | | |
|---|---|
| <input type="checkbox"/> TB, active, infectious (Class A, from Chest X-Ray Worksheet) | <input type="checkbox"/> Human immunodeficiency virus (HIV) |
| <input type="checkbox"/> Syphilis, untreated | <input type="checkbox"/> Hansen's disease, untreated multibacillary |
| <input type="checkbox"/> Chancroid, untreated | <input type="checkbox"/> Addiction or abuse of specific* substance without harmful behavior |
| <input type="checkbox"/> Gonorrhea, untreated | <input type="checkbox"/> Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur |
| <input type="checkbox"/> Granuloma inguinale, untreated | |
| <input type="checkbox"/> Lymphogranuloma venereum, untreated | *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics |

☐ **Class B Conditions** (From Past Medical History and Physical Examination Worksheets)

- | | |
|--|--|
| <input type="checkbox"/> TB, active, noninfectious (Class B1, from Chest X-Ray Worksheet)
Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed | <input type="checkbox"/> Hansen's disease, treated multibacillary
Treatment: <input type="checkbox"/> Partial <input type="checkbox"/> Completed |
| <input type="checkbox"/> TB, inactive (Class B2, from Chest X-Ray Worksheet)
Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed
See Section 4 on page 2 for TB treatment details | <input type="checkbox"/> Hansen's disease, paucibacillary
Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed |
| <input type="checkbox"/> Syphilis (with residual deficit), treated within the last year | <input type="checkbox"/> Sustained, full remission of addiction or abuse of specific* substances |
| <input type="checkbox"/> Other sexually transmitted infections, treated within last year | <input type="checkbox"/> Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur |
| <input type="checkbox"/> Current pregnancy, number of weeks pregnant _____ | *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics |
| <input type="checkbox"/> Other (specify or give details on checked conditions from worksheets) _____ | |

(2) Laboratory Findings (check all boxes that apply):

Syphilis: ☐ **Not done**

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Titer 1	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>		
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>		
Treated	If treated, therapy:				Date(s) treatment given (3 doses for penicillin)	
<input type="checkbox"/> Yes	<input type="checkbox"/> Benzathine penicillin, 2.4 MU IM					
<input type="checkbox"/> No	<input type="checkbox"/> Other (therapy, dose):E					

HIV: ☐ **Not done**

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Indeterminate	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secondary			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(3) Immunizations (See Vaccination Form, check all boxes that apply) **Not required for refugee applicants.**

- ☐ Vaccine history complete ☐ Vaccine history incomplete, requesting waiver (indicate type below)
- ☐ Incomplete vaccine history, no waiver requested ☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature

Panel Physician Signature

Date (mm-dd-yyyy)

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

- ☐ Check if therapy currently prescribed (if current, don't mark "End Date")

<u>Medication</u>	<u>Dose/Interval</u> <u>(i.e., mg/day)</u>	<u>Start Date</u> <u>(mm-dd-yyyy)</u>	<u>End Date</u> <u>(mm-dd-yyyy)</u>
<input type="checkbox"/> Isoniazid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin	_____	_____	_____
<input type="checkbox"/> Pyrazinamide	_____	_____	_____
<input type="checkbox"/> Ethambutol	_____	_____	_____
<input type="checkbox"/> Streptomycin	_____	_____	_____
<input type="checkbox"/> Other, specify	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Applicant's pre-treatment weight (kg) _____ Date (mm-dd-yyyy) _____

Remarks _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT

AUTHORITIES: The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

**CHEST X-RAY AND CLASSIFICATION WORKSHEET**

For use with TB TI 1991 and the DS-2053

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name (Last, First, MI.)		Age
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number
1. Chest X-Ray Indication (Mark all that apply) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> History of Tuberculosis (TB) Disease <input type="checkbox"/> Contact with Person with TB</div><div><input type="checkbox"/> TB Signs or Symptoms <input type="checkbox"/> Adult (With or without any of the other indications)</div></div> <p>(If child does not have any of the above, stop here.)</p>		
2. Chest X-Ray Findings <div style="display: flex; justify-content: space-between;"><div style="width: 30%;">Date Chest X-Ray Taken (mm-dd-yyyy) _____</div></div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"><div style="width: 30%;"><input type="checkbox"/> Normal Findings <input type="checkbox"/> Abnormal Findings (Indicate category and finding, checking all that apply, in the table below.) <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><input type="checkbox"/> Can Suggest ACTIVE TB (Need smears) <div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> Infiltrate or consolidation</div><div><input type="checkbox"/> Any cavitary lesion</div><div><input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculoma)</div><div><input type="checkbox"/> Pleural effusion*</div><div><input type="checkbox"/> Hilar/mediastinal adenopathy with or without atelectasis</div><div><input type="checkbox"/> Other (Such as miliary findings)</div></div><div style="font-size: small; margin-top: 5px;">* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.</div></div></div><div style="width: 30%;"><div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><input type="checkbox"/> Can Suggest INACTIVE TB (Need smears if symptomatic) <div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> Discrete fibrotic scar or linear opacity (fibrotic scar)</div><div><input type="checkbox"/> Discrete nodule(s) without calcification</div><div><input type="checkbox"/> Discrete linear opacity (fibrotic scar) with volume loss or retraction</div><div><input type="checkbox"/> Other (Such as bronchiectasis)</div></div></div></div><div style="width: 30%;"><div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><input type="checkbox"/> OTHER X-Ray Findings <div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> Follow-Up Needed (Mark as "Class B Other")<div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> Musculoskeletal</div><div><input type="checkbox"/> Cardiac</div><div><input type="checkbox"/> Pulmonary, non-TB (e.g., emphysema)</div><div><input type="checkbox"/> Other</div></div></div><div><input type="checkbox"/> No Follow-Up Needed for Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph nodes with calcified pulmonary nodule(s), or minor musculoskeletal findings</div></div></div></div></div>		

Remarks

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MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

U.S. Department of State
For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name (Last, First, MI)		Exam Date (mm-dd-yyyy)																																																																																																																																								
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number																																																																																																																																								
1. Past Medical History (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks) NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.																																																																																																																																										
<table border="0" style="width: 100%;"><thead><tr><th style="width: 10%;">No</th><th style="width: 10%;">Yes</th><th></th></tr></thead><tbody><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Illness or injury requiring hospitalization (including psychiatric)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cardiology</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina pectoris</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hypertension (high blood pressure)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cardiac arrhythmia</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congenital heart disease</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pulmonology</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of tobacco use</td></tr><tr><td></td><td></td><td>Current use <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic obstructive pulmonary disease (emphysema)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of tuberculosis (TB) disease</td></tr><tr><td></td><td></td><td>Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td></td><td></td><td>Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neurology and Psychiatry</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of stroke, with current impairment</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizure disorder</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Major impairment in learning, intelligence, self care, memory, or communication</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Use of drugs other than those required for medical reasons</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Addiction or abuse of specific* substance (drug)</td></tr><tr><td></td><td></td><td>*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other substance-related disorders (including alcohol addiction or abuse)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ever taken action to end your life</td></tr></tbody></table>		No	Yes		<input type="checkbox"/>	<input type="checkbox"/>	General	<input type="checkbox"/>	<input type="checkbox"/>	Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonology	<input type="checkbox"/>	<input type="checkbox"/>	History of tobacco use			Current use <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis (TB) disease			Treated <input type="checkbox"/> Yes <input type="checkbox"/> No			Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Neurology and Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	History of stroke, with current impairment	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self care, memory, or communication	<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)	<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	Addiction or abuse of specific* substance (drug)			*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics	<input type="checkbox"/>	<input type="checkbox"/>	Other substance-related disorders (including alcohol addiction or abuse)	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken action to end your life	<table border="0" style="width: 100%;"><thead><tr><th style="width: 10%;">No</th><th style="width: 10%;">Yes</th><th></th></tr></thead><tbody><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Obstetrics and Sexually Transmitted Diseases</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pregnancy Fundal height _____ cm</td></tr><tr><td></td><td></td><td>Last menstrual period Date (mm-dd-yyyy) _____</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sexually transmitted diseases, specify _____</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Endocrinology and Hematology</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes mellitus</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Thyroid disease</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of malaria</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Malignancy, specify _____</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic renal disease</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic hepatitis or other chronic liver disease</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hansen's Disease</td></tr><tr><td></td><td></td><td><input type="checkbox"/> Multibacillary <input type="checkbox"/> Paucibacillary</td></tr><tr><td></td><td></td><td>Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Visible disabilities (including loss of arms or legs), specify _____</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other requiring treatment, specify _____</td></tr></tbody></table>		No	Yes		<input type="checkbox"/>	<input type="checkbox"/>	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics and Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy Fundal height _____ cm			Last menstrual period Date (mm-dd-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Endocrinology and Hematology	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	History of malaria	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hepatitis or other chronic liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Hansen's Disease			<input type="checkbox"/> Multibacillary <input type="checkbox"/> Paucibacillary			Treated <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Visible disabilities (including loss of arms or legs), specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Other requiring treatment, specify _____
No	Yes																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	General																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Illness or injury requiring hospitalization (including psychiatric)																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Cardiology																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac arrhythmia																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonology																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	History of tobacco use																																																																																																																																								
		Current use <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Asthma																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (emphysema)																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis (TB) disease																																																																																																																																								
		Treated <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																								
		Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Neurology and Psychiatry																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	History of stroke, with current impairment																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self care, memory, or communication																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Addiction or abuse of specific* substance (drug)																																																																																																																																								
		*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Other substance-related disorders (including alcohol addiction or abuse)																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Ever taken action to end your life																																																																																																																																								
No	Yes																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics and Sexually Transmitted Diseases																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy Fundal height _____ cm																																																																																																																																								
		Last menstrual period Date (mm-dd-yyyy) _____																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases, specify _____																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Endocrinology and Hematology																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	History of malaria																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Other																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify _____																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal disease																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Chronic hepatitis or other chronic liver disease																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Hansen's Disease																																																																																																																																								
		<input type="checkbox"/> Multibacillary <input type="checkbox"/> Paucibacillary																																																																																																																																								
		Treated <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Visible disabilities (including loss of arms or legs), specify _____																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Other requiring treatment, specify _____																																																																																																																																								
2. Physical Examination (indicate findings and give details in Remarks)																																																																																																																																										
<input type="checkbox"/> No <input type="checkbox"/> Yes Applicant appears to be providing unreliable or false information, specify _____																																																																																																																																										
Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____																																																																																																																																										
BP _____ / _____ (mmHg) Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____																																																																																																																																										
*N, normal; A, abnormal; ND, not done																																																																																																																																										
N*	A*	ND*																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (including circumcision, infection(s))																																																																																																																																							
N*	A*	ND*																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (including adenopathy)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)																																																																																																																																							

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency (*Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form*) _____

☐ For continuing other treatment, specify _____

5. Remarks (*Describe any abnormal history, abnormal findings, and resulting interventions*)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.



VACCINATION DOCUMENTATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

For Use with DS-2053 or DS-2054 To Be Completed by Panel Physician Only

Name (Last, First, MI.)		Exam Date (mm-dd-yyyy)		REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS	
Birth Date (mm-dd-yyyy)		Alien (Case) Number		NOT REQUIRED FOR REFUGEE APPLICANTS	
1. Immunization Record					
Vaccine History Transferred From a Written Record (List Chronologically from Left to Right)					
Vaccine	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Vaccine Given by Panel Physician (mm-dd-yyyy)	Completed Series (✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)
Specify (check) vaccine: <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP					
Specify (check) vaccine: <input type="checkbox"/> Td <input type="checkbox"/> Tdap					
Specify (check) vaccine: <input type="checkbox"/> Polio - OPV <input type="checkbox"/> IPV					
Specify (check) vaccine: <input type="checkbox"/> MMR (Measles-Mumps- Rubella) <input type="checkbox"/> Rubella					
Specify (check) vaccine: <input type="checkbox"/> Measles <input type="checkbox"/> Measles - Rubella					
Specify (check) vaccine: <input type="checkbox"/> Mumps <input type="checkbox"/> Mumps - Rubella					
Rotavirus					
Hib					
Hepatitis A					
Hepatitis B					
Meningococcal					
Human papillomavirus					
Varicella					
Zoster					
Pneumococcal					
Influenza					
2. Results					
<input type="checkbox"/> Vaccine History Incomplete					
<input type="checkbox"/> Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate (as Indicated Above).					
<input type="checkbox"/> Applicant will request an individual waiver based on religious or moral convictions.					
<input type="checkbox"/> Vaccine history complete for each vaccine, all requirements met (Documented Above).					
<input type="checkbox"/> Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.					
				Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below	
	Not Age Appropriate	Insufficient Time Interval	Contra- indicated	Not Routinely Available	Not Fall (Flu) Season
3. Panel Physician (Name) _____					
Panel Physician (Signature) _____					
Date (mm-dd-yyyy) _____					

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

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